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CASE REPORT

Successful endovascular coil embolisation of a ruptured V1-segment vertebral artery dissecting aneurysm making a fistula with the adjacent vein

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SUMMARY

Sudden supraclavicular pain is often associated with myocardial infarction but seldom due to a rupture of V1-segment vertebral artery aneurysm. A ruptured V1 segment of vertebral artery dissecting aneurysm making a fistula with the adjacent vein has rarely been described in literature. Here we present a case of a 29-year-old healthy woman with sudden supraclavicular pain and palpable mass that developed after pain. Initial ultrasound showed suspicion of large haematoma. CT angiogram showed a left-sided dissecting V1-segment vertebral artery ruptured aneurysm. Angiography showed an additional fistula between the aneurysm and the adjacent vein. The patient was treated successfully with coil embolisation. The vertebral artery occlusion was well tolerated without any complications. Endovascular coiling is a fast and effective treatment modality. However, a parent vessel occlusion can be sometimes dangerous if the contralateral vertebral artery supply is not sufficient. Surgical possibilities to reconstruct the parent vessel should also be considered in complex cases.

BACKGROUND

Sudden onset of severe supraclavicular pain is often associated with myocardial infarction. Rarely, it could be due to an extracranial V1-segment vertebral artery aneurysm rupture. Extracranial vertebral artery aneurysms in the V1 segment are extremely rare¹ and the formation of a fistula of a ruptured aneurysm is even rarer.² These aneurysms are difficult to manage because of the high risk of

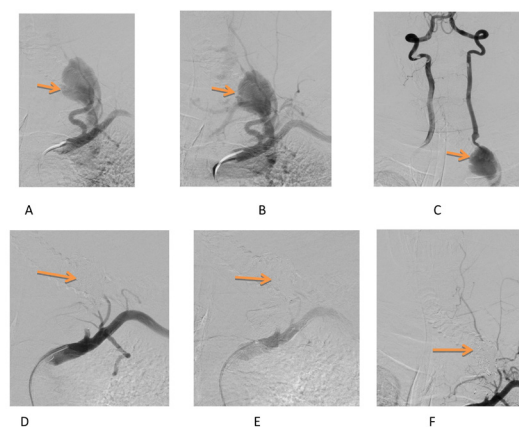


Figure 2 (A–F) DSA images showing different steps of intervention, including coil embolisation of the V1-segment vertebral artery aneurysm.

ischaemic complications to the posterior circulation. Both surgical and endovascular treatments carry potential risks and technical difficulties. The best treatment options are still controversial in such aneurysms.^{3–6} Here we present a case of a successfully treated ruptured dissecting V1 vertebral artery aneurysm making a fistula with the adjacent vein using endovascular coils and placement of a distal plug to close the fistula and proximally occlude the parent artery. This method was well tolerated by the patient.

CASE PRESENTATION

A 29-year-old woman presented with sudden supraclavicular pain and palpable mass above the supraclavicular region. She was otherwise healthy without any remarkable medical history. On examination the patient was alert, cranial nerves were intact, and no sensorimotor neurological deficits were present.

INVESTIGATIONS

Initial ultrasound showed suspicion of haematoma. CT angiogram showed a left-sided (3×2.8 cm) dissecting V1-segment vertebral artery ruptured aneurysm (figure 1A,B). Angiography showed an additional fistula between the aneurysm and the adjacent vein (figure 2A–C). A CT angiography of head and neck and a digital subtraction angiography (DSA) of neck vessels did not show any obvious signs of fibromuscular dysplasia. The patient was

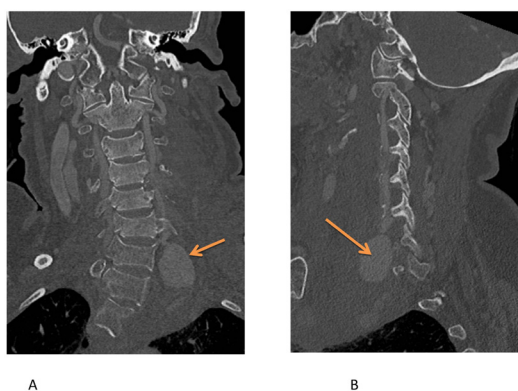


Figure 1 (A,B) CT angiography showing location and radiological anatomy of ruptured dissecting V1 vertebral artery aneurysm.



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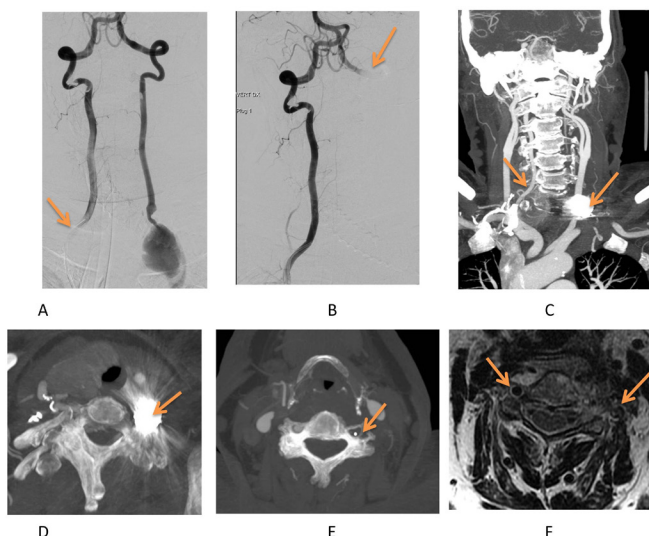


Figure 3 (A–F) DSA before (A) and after placement of a distal plug and filling from contralateral side (B) showing no more filling of right vertebral artery and aneurysm. Postinterventional CT-angiography (C,D,E) and MRI (F) showing complete occlusion and no more filling of the aneurysm.

admitted to our hospital for coil embolisation of the dissecting aneurysm as described above.

TREATMENT

After interdisciplinary discussion we decided on the endovascular treatment of choice. The contralateral vertebral artery was normal and the probability of tolerating an ipsilateral vertebral artery occlusion was high in this patient. An endovascular procedure with deposition of coils and placement of a distal plug to close the arteriovenous fistula (figure 3). We used two-micro-vascular plug (Reverse Medical), target XL coils (Stryker), and finally the proximal occlusion of vertebral artery was performed with the aim of interrupting the flow to the aneurysm and fistula point.

OUTCOME AND FOLLOW-UP

The patient tolerated the proximal vertebral artery occlusion very well. Postintervention images show a complete occlusion of the fistula and the parent vessel (figure 2A–F). No postinterventional neurological deficit was noted. The patient was discharged from hospital after 3 days. The patient was completely symptom-free after a follow-up of 4 weeks.

DISCUSSION

Extracranial vertebral artery aneurysms are extremely rare and account only for 0.5% of all aneurysms. Most extracranial vertebral artery aneurysms are located in the V3 segment followed by the V1 segment.⁷ These aneurysms are diagnosed secondary to an embolic infarct or incidentally as a palpable mass. Patients with connective tissue disorders, including Ehlers-Danlos syndrome, Marfan syndrome and neurofibromatosis type I are at higher risk of developing extracranial vertebral artery aneurysms. A ruptured vertebral artery aneurysm with local pain and haematoma are often found in this particular group of patients.^{3 4 8} In contrast, our case report presents a young patient without any trauma who presented with sudden onset of severe supra-clavicular pain. CT angiography and DSA are the standard tools to diagnose and reveal the anatomy of vasculature and to plan

Learning points

- ▶ Endovascular coiling is a fast and effective treatment modality. However, a parent vessel occlusion can be sometimes dangerous if the contralateral vertebral artery supply is not sufficient.
- ▶ Surgical possibilities to reconstruct the parent vessel should also be considered in complex cases.

treatment. Treatment options include ligation, isolation, balloon embolisation, onyx embolisation and coil embolisation.^{6 9–11} There is no single standardised treatment option for V1-segment vertebral artery aneurysms with a fistula. The anatomical location at C7–Th1 level might be difficult for end-to-side anastomosis with the carotid artery. The contralateral vertebral artery was slightly dominant, which supported the possibility to take the risk of endovascular proximal occlusion if needed. Hence, we decided on coil embolisation of the fistula. We could not reconstruct the parent vessel and thus we performed a proximal occlusion of the ipsilateral vertebral artery. Although endovascular modalities have a risk of embolic stroke, our patient tolerated the procedure well. The fistula (including dissecting aneurysm) was completely occluded and the patient had no adverse events.

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Contributors SM: manuscript drafting, patient care. MN: critical reviewed manuscript. JN: performed coiling. RR: performed coiling.

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